

MINUTES OF THE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairperson Landwehr at 1:30 p.m. on February 17, 2011, in Room 784 of the Docking State Office Building.

All members were present except:

Representative Phil Hermanson – excused
Representative Jim Denning – excused
Representative Valdenia Winn – excused
Representative Terry Calloway - excused

Committee staff present:

Norm Furse, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Martha Dorsey, Kansas Legislative Research Department
Dorothy Noblit, Kansas Legislative Research Department
Jay Hall, Kansas Legislative Research Department
Debbie Bartuccio, Committee Assistant

Conferees appearing before the Committee:

Dr. Daniel Minnis, DDS, Pittsburg, KS ([Attachment 2](#))
Dr. David Ferguson, DDS, Kansas City, MO ([Attachment 3](#))
Heidi Foster, Chief Executive Officer, Rawlins County Dental Clinic,
Atwood, KS ([Attachment 4](#))
Denise Maus, RDH, BS, Past President of Kansas Dental Hygienists' Assoc. ([Attachment 5](#))
David Sanford, CEO, Executive Director of GraceMed Health Clinic,
Wichita, KS ([Attachment 6](#))
Suzanne Wikle, Kansas Dental Project ([Attachment 7](#))
Ron Gaches for Maggie Smet, President of Kansas Dental Hygienists' Assoc. ([Attachment 8](#))
Kevin Robertson, CAE, Executive Director, Kansas Dental Association ([Attachment 15](#))
Dr. Paul Kittle, DDS, Leavenworth, KS ([Attachment 16](#))
Dr. Glen Hemberger, DDS, President, Kansas Dental Board ([Attachment 17](#))
Dr. John Fales, Jr., DDS, MS, President, Kansas Association of Pediatric Dentists ([Attachment 18](#))
Dr. Jeff Stasch, DDS, Garden City, KS ([Attachment 20](#))
Dr. Mark Herzog, DDS, Ellsworth, KS ([Attachment 21](#))
Dr. Cindi Sherwood, DDS, Registered Dental Hygienist & Dentist, Independence ([Attachment 22](#))

Others attending:

See attached list.

HB 2241 - Concerning the Kansas dental practice act and the franchising of dental practices.

Chairperson Landwehr proceeded to work the bill.

Revisor McBride reviewed four proposed balloon amendments ([Attachment 1](#)). Balloon #1 was proposed by Comfort Dental, Kansas Dental Association and Church Street Management. Balloon #2 was proposed by the Kansas Dental Board. Balloon #3 was proposed by all parties (Comfort Dental, Kansas Dental Association, Church Street Management, and the Kansas Dental Board). Balloon #4 was a technical amendment proposed by the Revisor. Balloon #5 was agreed upon by all parties and presented in the Kansas Dental Association's testimony at the hearing on February 15.

Representative Weber questioned whether on page 2 of balloon 3, line 33, does that change the relationship between those who are currently employed by an independent company, but not a franchise situation. John Federico, on behalf of Comfort Dental, indicated he did not believe so. Under no situation would a dental franchisor own or operate a dental practice or hire any staff or dentists.

Chairperson Landwehr made the suggestion that if we look at balloon #1, that we accept those two changes; that we accept balloon #3; on page 4, the technical for K.S.A. 21-3406.

Representative Bethel made a motion to adopt the amendments with the balloons that were just reviewed.

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The motion was seconded by Representative Bollier.

Representative Mah asked to confirm that there would not be a definition of unlicensed proprietor and Chairperson Landwehr responded that was correct.

Representative Crum spoke in opposition to the proposed amendment. He supported balloon #2 as he felt it was very important to include the definition of dental franchisor as outlined in balloon #2 that specifically does not allow a person or entity to effect the professional judgment of the dentist or contain terms that would constitute a violation of the dental practices act, rules and regulations adopted by the board, any orders and directives issued by the board. He also liked the line inserted on unlicensed proprietor as he felt that provided some safeguards to prevent undue influence on the professional judgment of a dentist. Even though we're comfortable with Comfort Dental, if we change this law, we don't know what other dental franchise entities might come into our state to take advantage of this opportunity and he believed the safeguards in balloon #2 should be included.

Chairperson Landwehr indicated it was her understanding we did not need the unlicensed proprietor because we defined proprietor with the idea that you're either licensed or unlicensed. This would keep us in uniform with the way definitions are handled in other statutes. Revisor McBride confirmed this understanding.

Representative Flaharty requested additional input from Comfort Dental and the Kansas Dental Association on the proposed amendment. Representative Otto asked if the second balloon was to give the Dental Board a reason to give them a cause of action.

Chairperson Landwehr then requested John Federico, Kevin Robertson and Betty Wright come forward for an informal discussion of the balloons. Betty Wright, Kansas Dental Board, indicated they felt it was important to have something in the statute that describes effecting the professional judgment of the dentist. There was discussion as to what is a definition of professional judgment. Kevin Robertson, Kansas Dental Association, indicated they are comfortable with the language in the bill and the language offered by Comfort Dental.

Chairperson Landwehr said it was her understanding that having read the bill in its introduced form, along with the amendments that have been proposed, that we have only clarified that Kansas will not go into corporate dentistry. There was discussion as to whether we have a statute on the books that already states we do not allow corporate dentistry and whether these changes are necessary. It was determined the Kansas Dental Board already has the authority to review contracts and to take action as needed. The intent of this bill is for the Kansas Dental Board to work with companies like Comfort Dental as they try to bring services into the state of Kansas for those who have a need for those services and to open up access.

At the conclusion of discussion, the motion from Representative Bethell carried.

Representative Flaharty made a motion to amend by adding the wording from the Kansas Dental Association testimony on February 15 as balloon #5. Representative Donohoe seconded the motion. The motion carried.

Representative Mah made a motion to add the word "limited" as shown on the Dental Board's recommendations on line 24 of page 1. The motion was seconded by Representative Flaharty. The motion carried.

Representative Bethell made a motion to pass the bill out as amended. The motion was seconded by Representative Weber. The motion carried.

HB 2280 – Kansas dental board; licensure of dental practitioners.

Chairperson Landwehr opened the hearing on the bill.

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Dr. Daniel Minnis, DDS, Kansas, presented testimony in support of the bill and has been in private practice in Pittsburg, Kansas for twenty-two years. ([Attachment 2](#)) He has provided care to Medicaid recipients, Head Start children, treated the mentally challenged, frail elders, individuals living with HIV and Hepatitis C and high risk pregnant mothers. He currently serves on the Board of Directors for the Community Health Center of SEK, a non-profit safety-net clinic. He founded the first CHC/SEK Dental Clinic in 2005. During his tenure at CHC they opened four Dental and Medical Clinics and will open a fifth clinic in Baxter Springs next month. He serves on the Board of Directors for Southeast Kansas Community Action Program (SEKCAP) Head Start and is a past board member of Oral Health Kansas and past chairman and adviser to the Kansas Mission of Mercy. He is also a volunteer faculty member of the University of Missouri Kansas City School of Dentistry.

In his time working to help ensure that all Kansans have access to quality dental care he has continuously run into the barrier of lack of dental providers in general and an acute lack of dental providers that will care for the underserved. In light of the aging dental workforce and the growing numbers of patients in need, the only systemic way he can see to address the issue of access to care is by creating a new member of the dental provider team.

Key points to consider include:

Life Threatening Illness

Dental decay is the Number #1 disease in children and left untreated can result in death. The child's ability to learn, play, and interact with others is impaired by dental disease. As we gather here today, Kansas children are enduring dental pain which can last for weeks or even months. The vast majority of these children are from low income families that have no access to care.

Workforce Issues in Rural and Underserved Areas

Recruitment and retention of dentists is difficult at best in our rural and underserved communities. Registered Dental Practitioners would play a vital and successful role in filling this void and easing the suffering of vulnerable populations. The most vulnerable populations are Medicaid and SCHIP children. With less than 10% of Kansas dentists providing significant care (treating 100 or more recipients/year) Medicaid and SCHIP children are at risk for serious illness resulting from untreated dental decay. Expanding the Dental Team to include a Registered Dental Practitioner will broaden and strengthen the dental provider community and will be a critical component of Kansas safety-net dental clinic care.

The New Dental Team

Upon graduation the RDP will have 3 ½ to 5 ½ years of education and training as compared to the 4 years of dental school for a dentist. Upon completion of the program the RDP will be trained to perform a narrower scope of practice than dentists, allowing the dentist to focus on more complicated dental procedures. Adding registered dental practitioners to the dental team will dynamically increase access to care and shortens the waiting time to schedule appointments in the dental clinic or office. It is not uncommon for a child to wait 2 months for a restorative dental appointment. With the RDP, as part of the dental team, many of these patients will be able to receive their needed dental care at the same appointment as their initial examination and cleaning, or within a few days rather than months.

The Gold Standard of Care

Every evaluation of dental mid-level providers prove that they provide safe, quality care and have for the last 80 years. There are no reports or research indicating standards of care less than that of a dentist. Kansas can be assured safe, quality care by developing the RDP model, which will be the gold standard in dental mid-level models. He expressed confidence in the Registered Dental Practitioner Model, the research that supports it, and the House Bill before you. He would hire a Registered Dental Practitioner in his practice and allow them to perform procedures within their scope on himself, his family members, and his patients. The RDP can and will play a vital role in saving teeth and saving lives in Kansas. Thank you for working diligently to protect the citizens and especially the vulnerable populations of Kansas. Testimony also included a letter to the editor from the former Vice-President of the American Dental Association and a "Keep Kansas Smiling" oral health grade card.

Dr. David Ferguson presented testimony in support of the bill. ([Attachment 3](#)) As a dentist who is

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passionate about public health and access to care for everyone, he believes the bill, through the creation of a mid-level dental provider, takes a long overdue step toward increasing access to dental care. His career began as a safety-net dentist in a community health center and he now has a private practice, where 50% of the children seen are on Medicaid. While he practices on the Missouri side of Kansas City, he is excited that Kansas is trying to improve access through the mid-level provider and wanted to participate. Included in his education and training was an internship spent in Alaska, the first state in the United States to implement a mid-level dental provider. That experience convinced him that mid-level providers are a crucial component of the dental team. The proposal put forth in this bill is a different, and stronger, educational model than Alaska, and if approved by the Legislature will prove to be a premier program in the country.

His testimony focused on the procedures that are proposed to be included in the scope of practice for the Registered Dental Practitioner and he concentrated on the procedures he believed would garner the most debate, and explained why they are critical components of the scope of practice for mid-level providers. He stated, unequivocally, these procedures can be performed in a high-quality and safe manner by mid level providers. Numerous studies have come to this conclusion, and there is absolutely no evidence to the contrary.

- **Extractions of primary teeth** – this is necessary treatment in providing care to children.
- **Nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility of +3 to +4. The registered dental practitioner shall not extract a tooth for any patient if the tooth is unerupted, impacted, fractured, or needs to be sectioned for removal** – these are teeth that are loose enough they move side-to-side and up-and-down.
- **Emergency palliative treatment of pain** – this is done to immediately relieve pain before the time a cure can be provided.
- **Cavity Preparation** – the provider uses the drill to remove decay.
- **Restoration of primary and permanent teeth** – this is putting the filling into a tooth that has had decay removed.
- **Preparation and placement of performed crowns** – the provider will place preformed crowns over teeth to reduce the likelihood of further decay and tooth breakage.
- **Pulpotomies on primary teeth** – this is a common procedure to provide pain relief to children. The procedure consists of removing the pulp in the upper tooth – taking the decay out. Often followed by the placement of a temporary crown.
- **Indirect and direct pulp capping on primary and permanent teeth** – a medicated material is placed inside of a cavity preparation before the filling material to insulate the pulp and promote healing.

The one point he wanted to leave about the scope of practice proposed in the bill is that it allows for treatment of dental disease rather than emergency stop-gap measures. Only by equipping a new level of provider with the skills necessary to provide treatment will we make a significant impact in increasing access to care.

Heidi Foster, chief executive officer of the Rawlins County Dental Clinic, a nonprofit safety net dental clinic serving 18 counties in Northwest Kansas, presented testimony in support of the bill. ([Attachment 4](#)) It took nearly 6 years for the community to establish a dental clinic for Rawlins County, but our clinic has grown exponentially in its first 18 months of operation. Due to continued growth we expanded to a new building in November 2010 and added a full-time dentist. We have also expanded our work to students in area schools, nursing homes residents, and patrons of developmentally disabled centers, by providing services such as cleanings, sealants, patient education, and fluoride varnishes.

In her work, she sees a persistent lack of dental care access. Our clinic staff provides an array of services to students in area schools, but our hygienists cannot diagnose decay under current practice acts. Our staff makes an effort to send letters home with students, alerting parents to potential problems with their

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children's teeth. However, many students' parents cannot provide transit to a clinic for themselves or their children do to the prohibitive distance. Then when we returned the following school year to perform preventative services, over 60% of these children with noted concerns have more areas of potential decay and the existing areas are much larger. So students qualifying for free or reduced cost lunches at public schools in Northwest Kansas receive semi-regular cleanings, but still don't have access to the regular care they need.

This is where the registered dental practitioner could fill the void. With the help of registered dental practitioners, young people and adults in Northwest and Central Kansas could access the full spectrum of dental care they need. Our most vulnerable patients' children, developmentally disabled, and frail elderly could receive services where they live and study eliminating barriers to full dental care.

Registered dental practitioners are necessary to fill the gap in Kansas because it seems as though we have exhausted other options for bringing care to people in rural areas. Even though Rawlins County Dental Clinic did recruit a second full time dentist, she only plans on staying until her loans are repaid through the state loan repayment. Upon completion of her obligation she plans to return to Omaha and open her own practice. Our second dentist that works three days per week is in his upper 70's. It's time to try something different.

Denise Maus, RDH, BS, Past President of the Kansas Dental Hygienists Association, presented testimony in support of the bill. ([Attachment 5](#)) She has been actively involved in dental hygiene for nearly 30 years, serving on many different boards in varying capacities. She is a clinical dental hygiene examiner for two different regional testing agencies and has participated on committees with each organization. She has been involved in dental hygiene education as an adjunct clinical faculty and was the lead hygienist organizing patient education at the past five Kansas Mission of Mercy's as well as attending all ten. In addition, she served on the Kansas Dental Board and recently completed a term as the Board President.

She appeared before the committee several years ago discussing what was then a perceived shortage of dental hygienists. The solution provided by the Kansas Dental Association at that time was to create a scaling assistant who could perform many of the same oral health services as a dentist hygienist until we could educate enough dental hygienists to fill the perceived shortages across the state. Since that time several dental hygiene schools opened throughout the state (increasing from two to five the number of hygiene schools in Kansas) which now provide us with approximately 100 graduates each year. In just the last three years alone, we have seen the number of actively practicing dental hygienist with practice locations in Kansas go from 1,529 to 1,750, an increase of 221 dental hygienists. In the same time frame, we have seen the numbers of actively practicing dentists with practice locations in Kansas increase only from 1,413 to 1,425, an increase of only 12 dentists. Although the state has licensed 2112 dentists and 2,404 dental hygienists, keep in mind that these numbers only tell you who holds a license and not their practice situation or what state they may reside in.

Options must be considered to increase the productivity of dentists, especially as we see much of our dentist population retiring in the near future. It is evident there is no shortage of dental hygienists and as time passes, there will be fewer and fewer dentists to work for, making the employment situation for hygienists even more difficult.

Another significant development related to access to care is the number of dental hygienists practicing with extended care permits. Dental hygienists with this special certificate may go into many different locations outside the dental practice to provide care to children and the elderly who are unable to acquire or access a dental home of their own at that time. To date, there have been 43 ECP I's and the 81 ECP II's issued to dental hygienists. Dental hygienists want to reach out and help provide care to these people but are limited by their scope of practice. The ECP III being proposed by the dental association is certainly one more step forward but still lacks many of the provisions provided for in this bill.

The concept of increasing the scope of practice of dental hygienists to include some of the simpler duties that a dentist can only provide at the current time has been around for many years. This year alone, there are several states looking at these very same issues about how citizens could better access and receive dental care. States as varied as Washington, Oregon, New Mexico and Connecticut and many in between

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are looking at practice issues and how to best provide dental care in their state.

Kansas is considering a great choice when we choose to use a dental hygienist who already has a vast amount of knowledge about dental hygiene, prevention of dental diseases and general dental knowledge to be a Registered Dental Practitioner.

The meeting was recessed at 3:20 pm. and then reconvened at 5:10 pm.

Dave Sanford, CEO and Executive Director of GraceMed Health Clinic in Wichita presented testimony in support of the bill. ([Attachment 6](#)) He also currently serves as Vice-President of the Board of the Kansas Association for the Medically Underserved, (KAMU), one of the partners in the Kansas Dental Project and on behalf of KAMU and the 39 safety net clinics in Kansas, he was there to speak in support of the bill. Eighteen of our member clinics provide dental services and maintaining an affordable and adequate work force is an ongoing challenge.

Not a day goes by at GraceMed's main dental clinic that we don't see a person who desperately needs dental care. For example, Shawna M., an 8-year old elementary school student from a small south central town had missed a number of school days because of pain associated with poor oral health. She was screened at school by one of our dental hygienists and found to have several cavities needing immediate attention. With no local dentist available, the uninsured mother did not know where to turn for care. The family qualified for Health Wave coverage and was referred to our main dental clinic for follow up care. As with many families in underserved areas, the mother was not aware of any local dental resources and, at the same time, felt that without insurance, her family was excluded from accessing private services in neighboring communities. If this bill is passed, perhaps in a few years, this family and others in that community will have access to some level of oral health care services provided by a competent, caring professional working under the supervision of a dentist in a neighboring town.

Registered Dental Practitioners (RDP) in Kansas are Registered Dental Hygienists who choose to obtain advanced training beyond their hygiene degree. This training for RDP's will be intensive, hands-on experience to master the approved scope of practice. By approving this legislation, you will be addressing the oral health care needs of thousands of Kansans who currently lack access to quality care in a more affordable system.

You have already heard the major concern this proposed bill addresses is access to dental care for underserved Kansans. It is a significant issue in the rural areas of the state, but I also want to share that access to dental care is a concern in some urban areas as well. In Wichita, we have a wonderful, engaged dental community. Many of our local dentists participate in the annual KDA sponsored *Mission of Mercy*; several local dentists participate annually in our *Give Kids a Smile Day* (free care for low-income, uninsured children); a number of dentists volunteer at the Sedgwick County Health Department's Children's Dental Clinic; and a number of dentists do provide some pro bono or reduced fee services for patients. Yet, even with these valiant local efforts, the demand for oral health care services exceeds supply. In 2010, GraceMed provided care for 13,705 unduplicated dental patients through 21,989 patient visits. This demonstrates, even in Wichita, that the current and projected number of dentists is simply inadequate to meet the demand for care.

The creation of a Registered Dental Practitioner in Kansas will not only make dental care more accessible, but more affordable as well. The opportunity for dentists to hire and supervise RDP's with a well-defined scope of practice will lead to the provision of cost-effective oral health care services. Since we are unable to meet the current demand for services in the State of Kansas, the passage of the bill will allow private practices and community health centers to hire RDP's and close the gap between demand and supply. The passage of this bill fits perfectly with the State's current emphasis on trimming costs while providing needed services. Ultimately, improving the overall health of patients is the long term objective of the Registered Dental Practitioner.

Several years ago, many physicians opposed the creation of the Physician Assistant and the Advanced Registered Nurse Practitioner (ARNP) models for some of the very same reasons you may hear. Today, though, most physician practices have employed mid-level providers and have increased access to quality medical care for their patients. This model has proven successful in addressing many of the same issues

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we are discussing today in the oral health care field. Medical mid-levels are now recognized as such an important component of the medical team that physician practices are required to employ at least a part time mid-level to be federally designated as a Rural Health Clinic.

System changes are always difficult to implement. Often, change is perceived as being either frightening or threatening because it's never been tried before. It is easier to stick with the 'status quo'. However, in this case, the current system is not sufficiently addressing the needs of all Kansans. There are simply too many real-life examples, like the ones mentioned earlier, that focus on access and affordability. Change can be challenging – but sometimes it's simply the right thing to do. As with the medical mid-level example, we will one day look back on the passage of this bill and rejoice in the fact that more Kansans have access to quality oral health care services.

Suzanne Wikle presented testimony in support of the bill on behalf of the Kansas Dental Project, a joint effort by Kansas Action for Children, Kansas Association for the Medically Underserved, and the Kansas Health Consumer Coalition. ([Attachment 7](#))

The Kansas Dental Project evolved out of a joint recognition by our respective organizations that Kansas must address our dental workforce shortage. For all the populations we represent – children, the patients of the safety-net clinics (Medicaid insured, uninsured and underinsured), and for all Kansans who seek affordable care, too often dental care is not accessible. The goal of our project and the bill is to create a sustainable solution to the dental workforce shortage in Kansas, thereby creating greater access, especially in the rural and underserved areas of the state.

Here are some facts about the dental access and workforce shortage problems in Kansas:

- Dental Care is the most frequent unmet health need of children.
- 55% of Kansas third graders have experienced dental decay; 25% of third grade children have untreated decay.
- 91 Kansas counties do not have enough dentists to serve their population.
- Only 1 in 4 dentists accept Medicaid; Only 10% of dentists see more than 100 Medicaid patients a year.
- The average age of a dentist in Kansas is 50, with older dentists practicing in more rural areas of the state.

The addition of a mid-level provider to the dental team is an absolute necessity to finding a long-term solution. Without an additional provider, equipped with the skills to provide treatment of dental disease, the workforce shortage will continue to worsen. The Registered Dental Practitioner proposed to you is a Kansas specific model that has been crafted to utilize the resources in Kansas in order to meet the needs of our state. The education, supervision, and scope included in the bill are the right fit for Kansas because we can use the existing dental hygiene education system and because it will create greater access to dental care, especially for the underserved populations and rural areas of our state.

Access will be increased by:

- Allowing safety-net clinics to serve more people in a more efficient and affordable manner.
- Expanding the reach of safety-net clinics by using RDPs in the "hub and spoke" system.
- Provide private practice dentists with a more affordable way to treat patients insured through Medicaid.
- Expanding the reach of private practice dentists in rural areas by allowing RDPs to work in neighboring communities.

Key Parts of HB 2280 Include:

Education

Registered Dental Practitioners will be hygienists that choose to obtain 18 months of advanced training beyond their dental hygiene degree. The training program for RDPs will include intensive, hands-on experience to master their scope of practice. Kansas is well-positioned to create training programs for this new career path. Across the state there are five dental hygiene schools, potentially allowing RDPs to be trained close to the communities they will serve.

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Supervision

Registered Dental Practitioners must be supervised by a dentist; they will not be practicing independently. There are two types of supervision levels under which RDPs may practice: direct and general. Under direct supervision, the RDP must practice in the same setting as the dentist. Under general supervision, the RDP may practice in a different setting after receiving permission from their supervising dentist. As part of general supervision, the dentist may limit what services the RDP may provide, and through a written supervision agreement the dentist and RDP will have protocols in place for unintended complications. All RDPs must work under direct supervision for at least 500 hours before being able to work under general supervision.

Scope of Practice

The services that may be provided by an RDP include all the services provided by Registered Dental Hygienists plus additional services, including fillings, cavity preparation, extractions of baby teeth, and extractions of already loose permanent teeth. The supervising dentist may limit the scope of an RDP under their supervision through the written supervision agreement.

Registered Dental Practitioners will bring a valuable combination of skills to the dental team – they will be able to provide the education and preventative care of hygienists and basic restorative care needed to alleviate pain and treat dental disease.

Practice Locations

To ensure that Registered Dental Practitioners will serve the communities that need them most, parameters around practice locations have been included in the legislation. RDPs would be required to meet one of the following standards: work in a federally designated workforce shortage area; be employed by a safety-net clinic; or work for a private practice that derives at least 20% of their revenues from Medicaid.

Members of the Coalition include: Association of Community Mental Health Centers, Kansas Advocates for Better Care, Kansas Area Agencies on Aging Association, Kansas Association of Community Action Programs, Kansas Association of Homes and Services for the Aging, Kansas Chapter of the American Academy of Pediatrics, Kansas Children's Service League, Kansas Dental Hygienists Association, Kansas Farmers Union, Kansas Health Care Association, Kansas Public Health Association, Kansas Statewide Homeless Coalition, Keys for Networking and Youthville.

The Kansas Dental Project appreciates the opportunity to appear before you today and we strongly urge your support of the legislation.

Ron Gaches provided testimony in support of the bill on the behalf of Maggie Smet, RDH, and President of the Kansas Dental Hygienists Association. ([Attachment 8](#)) Ms. Smet is a registered dental hygienist with 20 years experience in both public health and private practice. She has participated in all 10 Kansas Mission of Mercy (KMOM) dental projects. Since 2003, 19,173 patients have received dental care through one of the ten KMOM projects with total care valued at \$9.6 million. But what about the rest of the dentally underserved Kansans that were not lucky enough to get care from a KMOM project?

Time and time again patients of KMOM state when interviewed that they do not have the large amount of money needed to see a private practice dentist. The initial exam and a dental x-ray to check one painful tooth can run up to \$100. This does not include any treatment to relieve pain or repair to a tooth! Therefore, we often hear that many Kansans go without dental care of any kind.

Thankfully, Kansas has 19 wonderful safety net dental clinics placed across our state. We also have Extended Care Permit dental hygienists who may take preventative oral health care into alternative not-for-profit settings to help meet the needs of underserved Kansans. Safety net clinics are a great source of dental services that are based on income. These clinics employ passionate dental teams that deliver quality dentistry for all.

As a previous employee of Health Ministries Clinic, she is proud to have given many people preventive dental treatment with her Extended Care Permit. Oftentimes, she worked with no dentist in the office, and for a while, worked when the clinic had no dentist employed. They could only offer dental cleanings.

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She saw a lot of patients in pain that she could only take an x-ray on and try to get them into a private practice to receive restorative or extraction services. This was a huge challenge due to the high cost. The patients most often endured the pain permanently or waited for months to receive an appointment at a safety net dental clinic in a different city.

Safety net dental clinics often have trouble finding and retaining a dentist due to lower salary and very few dentists wanting to work in public health. Additionally, Kansas has only licensed 25 dentists since 2005. (Cited from Dave Ranney, KHI News Service, August 30, 2010 "*Slow going in efforts to solve state's dentist shortage*" "*Anticipated retirement of veteran dentists could worsen access problems in rural areas*") As you may have heard, there is a well-documented access issue in Kansas when it comes to dental care. In Kansas, 91 of our 105 counties (86%) do not have enough dentists to serve their population. All or a portion of each of these 91 counties have received a federal designation as a workforce shortage area. Looking ahead, the average dentist in Kansas is approaching retirement age with no dentist in sight to replace them. Once these dentists do begin to retire, it will further exacerbate the dental workforce shortage we're facing right now.

The workforce problems in Kansas are only expected to get worse, especially in the rural area of the state. Now is the time to create a system solution that provides a long-term, sustainable solution – adding a new provider to the dental team.

The Kansas Dental Hygienists' Association advocates for the creation of the Registered Dental Practitioner – RDP. This new member of the dental team will be a registered dental hygienist with additional education. The RDP will be able to provide dental services that will be hugely beneficial to those clients that receive services from public health centers. These services will include performing fillings for children that receive services from public health centers. These services will include performing fillings for children and adults, extraction of non-restorable baby teeth, as well as emergency palliative treatment for those who come to the clinic in pain. A list of 34 procedures exists in the bill that the RDP can provide. Many of the procedures are services that a registered dental hygienist can already provide AND some of the procedures are also listed in **SB 132 - Dental care; increasing availability and access to dental care**, proposed legislation which both the Kansas Dental Association and the Kansas Dental Hygienists' Association collaborated together to allow a registered dental hygienist (RDH) with an Extended Care Permit III to perform in the same public health locations.

The most important section is the collaboration that will exist between the registered dental practitioner (RDP) and a licensed dentist. KDHB strongly advocates for the continued collaboration between dentists and all members of the dental team. In fact, the registered dental practitioner (RDP) will have a written agreement with a supervising dentist. The RDP will have written protocols in place that will outline a course of action when the RDP encounters a patient who requires treatment that exceeds the authorized scope of practice of the RDP. The supervising dentist must ensure that a dentist is available, in person or through distance technology, to the RDP for timely consultation if needed, and must either provide or arrange with another dentist or specialist to provide the necessary treatment to any patient who requires more treatment than the RDP is authorized to provide.

Patient safety is a priority in this proposed legislation. Superior education will be imparted on the RDP and includes knowing the scope of practice as well as the RDP's ability to know when a procedure is beyond their capability. Scare tactics are not a viable option to maintain the status quo. Appropriate training is the answer for all members of the dental team. The training will begin with a Registered Dental Hygienist who already has a minimum of 3 years college education (Associate Degree), has passed a national and clinical exam and has a state license and will receive 12 months to 18 months of additional education for delivering basic dental services to the underserved.

Dental Hygienists in Kansas outnumber dentists by several hundred. Kansas graduates up to 100 registered dental hygienists yearly from the five dental hygiene programs. We rely on graduates from dental schools outside our state to come to Kansas and practice. Most dentists settle in a suburban city vs. a rural area to practice. In the last few years, dental hygienists have had trouble finding employment due to the congestion in their field. It seems like a natural transition to educate a dental hygienist as a registered dental practitioner and employ them in the ever growing and always needed field of public health. All Kansans need and deserve good oral health.

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Mike Hammond, the Executive Director of the Association of Community Mental Health Centers (CMHCs) of Kansas, Inc., provided written testimony only in support of the bill. ([Attachment 9](#))

The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems.

Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the “safety net” for Kansans with mental health needs, collectively serving over 118,000 Kansans with mental illness.

It is important to note that one in four adults—approximately 57.7 million Americans—experience a mental health disorder in a given year.^[1] Evidence suggests that individuals with mental illness are at a greater risk of oral disease and have greater oral treatment needs^[2].

Numerous factors influence oral health, mitigate against self-care, and affect routine access and provision of oral health care in adults with psychiatric conditions. Cost of the care and dental phobia are the mostly reported barriers to dental care in psychiatric patients. Poor access to dental services is another significant factor as well^[3]. We know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than \$20,000 a year. Creation of a Registered Dental Practitioner would be a cost-effective solution to increase access to dental services for all Kansans with mental illness.

Additionally, increased preventive dental access for individuals with mental illness that are on Medicaid, would save the State money as fewer individuals would show up in emergency rooms and community hospitals with dental-related problems. In an era of higher medical spending across the health care spectrum, the State should explore opportunities that would ultimately bend the cost curve.

Thank you for your support of mental health care and treatment for all Kansas, and the adoption of this bill which would enhance dental care access.

[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408, 409, 411.

[2] Dicks JL. Outpatient dental services for individuals with mental illness: a program description. *Spec Care Dentist*. 1995 Nov-Dec;15(6):239-42.

[3] Matevosyan NR. Oral health of adults with serious mental illnesses: a review. *Community Ment Health J*. 2010 Dec;46(6):553-62. Epub 2009 Dec 29.

Tanya Dorf Brunner, Executive Director, Oral Health Kansas Inc., presented written testimony only in support of the bill. ([Attachment 10](#)) Oral Health Kansas is the statewide advocacy organization dedicated to promoting the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter. We achieve our mission through advocacy, public awareness, and education. Oral Health Kansas has over 1,100 supporters, including dentists, dental hygienists, educators, safety net clinics, charitable foundations, and advocates for children, people with disabilities and older Kansans.

We see three types of barriers to accessing oral health in our state: access to a payment source; access to a provider; and willingness to access services. A variety of approaches to all three types of access must be present in order for all people to have adequate access to oral health care. With our partners in the oral health field, we are working to address each of these through a variety of means.

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Oral Health Kansas recognizes the need to expand and strengthen the dental workforce in Kansas. We believe access to both a provider and a payment source need to be strengthened in order to ensure all Kansans have access to good oral health care. Without a funding source, people do not have access to dental services. Likewise, without a dental provider, people do not have access to dental services. Both are critical, and one of our key priorities is to strengthen the Kansas Medicaid program by ensuring all people eligible for the program have access to dental services.

Our board support the efforts being undertaken to address dental workforce issues through this bill and **SB 132**. Representing an objective, third party advocacy organization, we encourage you to support the bill to address the general, statewide interest in expanding and strengthening access to oral health services. Oral Health Kansas is dedicated to collaboration; as such, we encourage the parties working on dental workforce models to collaborate on a model that works best to meet the oral health needs of all Kansans.

Dr. Kathy Weno DDS, JD, Director of the Bureau of Oral Health at the Kansas Department of Health and Environment, the State Dental Director, presented written testimony only in support of the bill. (Attachment 11) The Bureau of Oral Health is the state's public health section dedicated to oral health. We collect data on the oral health of Kansans, administer a Dental Recruitment program and provide funds for community based oral health improvement projects.

The sufficiency of Kansas' dental providers to meet the oral health needs of Kansans is an issue the Bureau of Oral Health has been working on for several years. In 2009 the Bureau completed a workforce research project, the "*2009 Kansas Oral Health Workforce Assessment*". Utilizing this research, we were able to secure a federal grant to create the Kansas Dental Recruitment Program. The program employs a full time workforce specialist to assist rural dentists and safety net clinics in dental professional recruitment and offers workforce incentives like student loan re-payment and provider grants to subsidize community based projects like school sealant and nursing home programs. We also created "Dental Club", a program for high school students to interest them in dental careers. Dental Club provides students with work/study and mentoring opportunities as well as college scholarships for students willing to commit to a dental career. Lastly, the grant includes an on-going task group, the Dental Workforce Cabinet, where a diverse group of stakeholders work together on workforce issues.

Kansas currently has 1,425 active licensed dentists that practice mainly in population centers across the state. Thirteen counties in Kansas have no dentist, and 80% of these counties are in sparsely populated parts of Western Kansas. The average age of a Kansas dentist is 50, but as the population of a Kansas county decreases, the age of their dentist increases. The average age of a dentist increases to 57 in a frontier county. 54.3% of these dentists plan to retire in the next 3-5 years. Recruiting dentists to work in Kansas is difficult. For dentists who reported their practice was for sale, 75% indicated the practice had been for sale for a year or more. Among those looking to hire an additional dentist to their practice, 48.5% reported that recruitment had been difficult.

Currently the Bureau is working with researchers at the University of Kansas Medical Center on a new dental workforce research project using population data and geo-coding to identify areas in Kansas that are without convenient access to dental care. The project is on-going but as it is particularly relevant to this hearing, I have included two maps from this research with this testimony. Figure One is a map of all of the dental practices in Kansas, placed on a background indicating the county's dentist to population ratio. The dot on the map indicates a dental practice location, and the white box is the total number of dentists located within the county. The more darkly colored counties indicate counties with fewer dentists practicing in a county with a significant population density. Based on this information, it appears that Kansas dentists are relatively well situated to meet the needs of the state's population. Counties with low population densities may have few or no dentists, but looking at the map as a whole, a dental practice is usually located nearby. If the Bureau utilized this map to determine where new access points should be created, we would concentrate our efforts in north central and south western Kansas where the dentists are few and the population is sufficient to support a new dental practice or a community based dental program.

The plotting of dental practices on a map in relation to population density is a useful tool, but the Bureau of Oral Health realizes that it does not tell the whole story. The presence of a dental practice in a county does not guarantee access to dental services for all sections of the population. Most dentists limit their

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practices to those with dental insurance or the ability to pay. For uninsured populations and children on Medicaid, access is much more challenging. Kansas Medicaid provides only children with a full dental benefit; dental services for adults on Medicaid are limited to emergency services only. Kansas Medicaid pays dentists around 60.5% of their median retail fees, and the majority of Kansas dentists do not participate. Last year, only 412 dentists filed a Medicaid claim. Even fewer dentists see a significant number of Medicaid patients on a regular basis. Figure Two maps the number of dentists who received \$10,000 in Medicaid claims payment in FY 2010. This includes only 222 dental providers. In 2007, only 41.2% of Kansas Medicaid enrolled children received a dental service.

The Bureau of Local and Rural Health applies for federal designation of Dental Health Professional Shortage Areas (HPSAs). HPSAs exist in areas that have a high ratio of population to dentists or a high ratio of certain populations to dentists, such as low-income or those enrolled in Medicaid. This designation is used to identify these areas to support the most effective targeting of resources by federal programs, such as the National Health Service Corps. There are currently 27 full county-dental HPSAs in Kansas; meaning that there exists a high ratio of population to the total dentists in these areas and that there is not reasonable access to dentists in other areas. There are also 62 full-county designations for the low-income or Medicaid populations along with the cities of Wichita and Topeka, meaning that there exists a high ratio of the indicated population to dentists that serve the population in these areas and there is not reasonable access to dentists in other areas serving the population.

This bill would create a new dental provider (called a Registered Dental Practitioner) that is intended to treat Medicaid and other underserved populations. The Bureau of Oral Health supports innovative proposals that could increase access to dental care. The new proposed practitioner is a registered dental hygienist with additional training in restorative and surgical procedures. A community based dental hygienist model is not unprecedented in Kansas. In 2003 the Kansas Dental Practice Act was amended to allow a dental hygienist to practice relatively independently in community sites if they received an Extended Care Permit (ECP). These ECP hygienists are able to work in community sites (schools, nursing homes, senior centers) although they do not have an expanded scope of practice and can only do hygiene services. The proposed Registered Dental Practitioner (RDP) would be allowed to do more, including restorative and surgical procedures in federally designated shortage areas and other community sites. This provision is meant to restrict a RDP's practice to underserved populations, but as mentioned in the previous paragraph, with 91 out of 105 counties designated, they could practice almost anywhere.

The Registered Dental Practitioner would be unique to Kansas. No other state has yet implemented this type of model, so there is no data to estimate what (if any) impact a RDP would have on dental access. It is important to note that the Extended Care Permit has not been well utilized by hygienists. Only 124 out of a total of 1,750 hygienists currently have ECPs, and most do not use the permit in their day to day dental hygiene practice. The new RDP training curriculum is much more rigorous and expensive than the ECP requirements. Based on the state's history with the ECP, it may be difficult to recruit dental hygienists to this new practitioner model. It is also unclear how many dentists would be willing to be RDP supervisors or train hygienists to be RDPs.

The Bureau of Oral Health is committed to improving the oral health of all Kansans. This includes improving dental access for underserved populations, including those without dental insurance and on Medicaid. The Bureau encourages innovative workforce solutions, like the one proposed in this bill. Thank you for the opportunity to provide these written comments.

Dr. Melinda Miner, DDS, presented written testimony only in support of the bill. ([Attachment 12](#)) I wish I could come to Topeka in person and testify but with only a week notice I simply could not make it today. Please understand that this is very important to me and beneficial to the people I serve. My husband, Dan Miner DDS and I own a private dental practice in Hays Kansas that serves a clientele of about 50% Medicaid children. Dan, from Western Kansas, had always wanted to come back home after graduation. We needed a town that could handle two new dentists. Although Hays had quite a few dentists in 2000 there was no Healthwave provider in Hays and there had not been one for about 3 years. Children were not getting dental care and that was not ok. We fell in love with Hays and decided that the town could benefit from our help. We have accepted Medicaid since we hung a shingle and opened our doors in August of 2000. Ten years later we are still the only private practice in Hays that accepts Medicaid (Healthwave). Our little patients frequently come from over 60 miles away. There are few dentists that enjoy treating children and even fewer that will accept Healthwave. For financial reasons we had to start a

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waiting list about 3 years ago; although we do still take these new Medicaid patients in at a rate of about 10-15 new children per week, we cannot keep up with the need. A couple of years ago a FQHC opened in Hays but even with that we currently have a waiting list of over 150 children with Healthwave that need a dental appointment. We are the people in the trenches.

The house bill providing for a Registered Dental Practitioner (RDP) or a mid-level provider is ideal for a practice like ours. It is very hard to attract a new dentist to Western Kansas and even harder to get them to stay. Being largely Medicaid based we cannot offer the compensation that a new graduate demands. It's hard to send a college student off to UMKC dental school as there are few spots for Kansas residents. Getting them to return to small town life after graduation is even harder. Properly training a RDP in a rural based school (utilizing one of the current RDH schools) and working with the RDP in a team environment would be beneficial to Western Kansas. In our practice adding just one RDP would help to open up appointments for those kids on our waiting list allowing us to see about 30-40 additional kids per week. It would also allow outreach once per week to those towns we currently serve like WaKeeney and Ness City.

The main argument I keep hearing against the RDP seems to be a question of public safety. The proposal before you provides for 18 months of intense dental training. This is on top of the 2 year RDH degree that is required for admission to the program. The bill also provides for a required apprenticeship of at least 500 hours with the supervising dentist and a written contract that specifically states the allowed scope of practice and when the supervising dentist must be called in to help out. Any dentist that would employ a RDP would understand that they are ultimately responsible for the successes and the failures of that employee. Any dentist that would agree to supervise, and then fail that RDP by not ensuring quality, would have to face the dental board when the outcome is not good. Just as any other employee there is a responsibility to assure quality in what they do for us. As long as the RDP is held to the same standard of care, the same continuing education requirements, and they are supported by their supervising dentist, there is no need to worry about the final product. Realistically, requiring the RDP pass a clinical and written board examination will ensure that they can produce a quality product. If they were to take the exact dental board as the dentists from UMKC and were to pass would we not agree that they are competent to practice? I would ensure quality from my RDP; they will be treating my patients.

It seems that the Kansas Dental Association opposes this model. Being a KDA member for the last 11 years I was saddened to discover that this was not discussed with the membership before it was opposed without compromise. In fact when a few of the members tried to discuss this matter the KDA put an end to our discussions. Although they do not admit it they have presented you with their version of a mid-level in SB 132. They call their provider an Extended Care Permit (ECP) III. This ECP III would "assess" not diagnose a patient and would remove this assessed decay with a hand instrument and place a temporary filling. They would do this with only 18 hours of training, no examination, and no direct supervision. They already allow an ECP I to "assess" a patient without a dentist ever seeing the patient and declare a tooth cavity free, they even currently allow them to place a restorative material called sealant on that tooth. ECP I permit simply requires a hygienist pay a \$5 fee and no additional training is provided to help them learn how to "assess" that a tooth does not have disease. The KDA's argument that this is quality care is certainly not the standard of care I want in my practice or for my community.

Many of the dentists that oppose this RDP model are also unwilling to sign up to be Medicaid providers. I have heard that only 25% of us are providers for the healthwave program. The dentist's arguments are many and they are valid and right for their practice. I am not in favor of the government mandating that they sign up. We all have to do what is right for the patients we choose to serve. The reality is that we are the providers for a lot of the low income children of Western Kansas. We are the ones that would utilize this model and our patients would benefit from it greatly. We support HB 2280. We would be responsible for the outcomes in our office and we would assure the same quality. I ask the 75% of Kansas dentists whom are not healthwave providers; why are you opposed to something that would help me to serve my low income patients better when you are not willing or able to help me? Why don't we ask the families on our waiting list or the people of the 14 counties without a dentist what they think? Thank you for your time.

Written testimony only in support of the bill was provided by Jason Wesco, Chief Operations Officer, Community Health Center of Southeast Kansas. ([Attachment 13](#)) My organization provides access to medical, behavioral and dental care services to all individuals regardless of their ability to pay. Last year we cared for more than 23,000 patients during nearly 80,000 visits to clinics located in Pittsburg,

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Columbus and Iola. Our dental program employs five full-time dentists and ten dental hygienists (all with Extended Care Permits) that offer services in four clinical locations and on-site in schools, Head Starts and long-term care facilities across Southeast Kansas. The growth in our dental services has been significant since the inception of the program in 2006. Last year we cared for 12,000 dental patients during more than 21,000 visits.

In my work at CHC/SEK, I am responsible for all aspects of our dental program, from new program development and strategic planning to recruiting dentists and dental hygienists. In this capacity, I have seen first-hand the critical lack of access to dental care that exists in rural Kansas, not just for the underserved, but for entire communities. As a Community Health Center, we concern ourselves with access to care for everyone, not just the underserved. And we are very concerned about the current and especially the future of access to oral health care in Kansas.

Since inception, our dental clinics have cared for patients from twenty-six Kansas counties and we regularly see patients that drive from 75 miles away to obtain affordable dental care. This demand has been the impetus for the rapid expansion of our dental program, but even with our expansion we are still hopelessly understaffed. In Southeast Kansas alone, there are almost 70,000 low-income individuals in the nine county region – nearly 40% of the total population. But the problem doesn't stop here. There are about 175,000 individuals in our region and, at my last count, 44 general practice dentists (and no pediatric dentists, no endodontists and just one oral surgeon). That's one dentist for every 3,977 residents. By my calculations, the ratio in Kansas is about 1:2,500, and in the nation about 1:1,100. By any measure we are underserved.

To further compound the problem, we have an aging dental workforce. According to KDHE's Bureau of Oral Health's recent workforce survey, the average age of a dentist practicing in rural Kansas is about 55. With the increasing demand for care and the decreasing supply of dentists, we are facing a crisis in access to dental care of increasing severity over the next 10 years – assuming attrition in providers that tends to come with an aging workforce. In some of our counties over that time, I anticipate that we may be the only source of dental care available for anyone, insured or not, wealthy or poor. This reality will strain our resources tremendously. In fact, there is no way, given the current environment, we would be able to provide adequate access to care to additional patients.

The bill proposes the creation of a Registered Dental Practitioner, a mid-level provider that would function much the same way as Advanced Registered Nurse Practitioners and Physician's Assistants do in the medical field. The RDP would work under the supervision of a dentist through a collaborative agreement, an agreement that could restrict the RDP's scope of practice beyond the proposed legislation. The RDP could work under direct or general supervision, essentially freeing them much as medical mid-levels are freed, to practice without a doctor on-site.

For us, the RDP would mean the ability to greatly expand access to quality dental care, in the same way that we use medical mid-levels to extend the reach of our physicians. In our medical practice, we employ six full-time physicians and six full-time nurse practitioners. I expect the same kind of ratio in our dental practice if we were to have access to RDPs. If we were to hire six dental mid-levels, we estimate that an additional 8,000 patients could be cared for during 15,000 visits each year.

The RDP would mean an increased provider pool for us to recruit from. Currently, of the five dentists we employ, only one is a Southeast Kansas native, a fact that could lead to long-term retention issues. Expanding the dental provider pool to include RDPs would increase the likelihood of finding regional natives that would choose to practice (and remain long-term) in the area. This increased provider pool would allow us to increase capacity at our current clinical sites and to more readily expand into communities where CHC/SEK does not currently have a physical presence.

In short, the RDP is the best tool we have at our disposal to help eliminate numerous barriers that many Kansans face today in accessing oral health care. Over the next decade, the conjoined problems of access to care and the declining dental workforce, problems that have traditionally affected the uninsured and those with public health benefits, threaten to make most Kansans "underserved."

This legislation before you appeals to, as Lincoln said, "the better angels of our nature." It says "yes" to our fellow Kansans in need who are so accustomed to being told "no." It illustrates our heritage as a people who seek out, find and implement unique solutions to complex challenges. It carries on the proud Kansas tradition of passing progressive legislation in the public's interest.

We, as a state, can lead on this issue. On behalf of our board, staff, patients and most importantly those

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we are as yet unable to serve, I ask that you support this important piece of legislation. Thank you for considering my testimony. Best wishes as you deliberate on this matter.

Janette Delinger, RDH, BSDH, presented written testimony only in support of the bill to increase access to basic and preventive dental services for the underserved and unserved populations through the development of the Registered Dental Practitioner. (Attachment 14) Kansas have been suffering for many years due to the shortage of dentists in our state. Currently 91 of 105 counties are without enough dentists to take care of the population (as well as the lack of Medicaid providers) and are designated by the state as Health Professional Shortage Areas (HPSA).

Development of a mid level dental provider is very comparable to the medical profession's nurse practitioner. A registered dental hygienist (RDH) has a minimum of an Associate Degree with at least 3 years of college, passed a national board exam, clinical exam and a state ethics and jurisprudence test given by the Kansas Dental (KDB) before becoming licensed to practice in the state of Kansas. Having a RDH as the starting point for the RDP program is exactly where a mid level provider should begin. The RDH would become a RDP by completing curriculum of at least 12 months, but not more than 18 months at an accredited institution, completing a clinical examination and then be licensed as an RDP (also retaining their RDH license). The RDP education will continue to build on the RDH's dental knowledge by further expanding their clinical skills to include basic dental services alongside their full preventive services to provide care for specific target populations in specific practice settings. The bill has been well written and parallels existing models already in development in Minnesota, where they expect to graduate their mid level practitioners in May 2011.

It surprises me that the Kansas Dental Association is talking about their concern for the public's safety regarding the RDP proposal when they didn't seem to be concerned about public safety when they developed the scaling assistant legislation that passed in 1998. The KDA scaling assistant proposal allowed dental assistants, who did not have to have any formal training, to take a 10 day course to be able to provide dental hygiene services (normally provided by an RDH). Scaling assistants are not required to have any accredited formal training, take any kind of national, clinical or ethics exams and are not registered by the state of Kansas. This legislation was developed due to the perceived lack of dental hygienists in the rural areas. According to data from the Kansas Dental Board, a majority of scaling assistants are working in the five urban counties that are not designated as HPSAs.

Now is the time to be proactive for the underserved and unserved populations that cannot speak for themselves. Let's do what is right for Kansas and give those in need good, basic and preventive care dental services that will have a huge impact in improving their overall health. I urge you to support this bill.

Kevin Robertson, executive director of the Kansas Dental Association, presented testimony in opposition to the bill. (Attachment 15) The Kansas Dental Association represents 1,250, or some 77% of the state's licensed dentists and appreciates the opportunity to discuss with you the Kansas Dental Associations' thoughts on the bill.

The Kansas Dental Association (KDA) believes that all Kansans deserve access to safe quality oral health care and to a dentist to provide for their diagnostic, restoratives, and surgical dental needs. As such, the KDA is **STRONGLY OPPOSED TO** the bill.

With me today to discuss concerns are a few of the **OVERWHELMING** majority of dentists across Kansas that believe the bill jeopardizes patient health and safety. First, let me take a minute to discuss the dental workforce and dental access in Kansas. The KDA has stated that the dental workforce is improving in Kansas. In fact there are exciting things going on in Kansas! As recently as 2004, Kansas had only nine dental students graduate from UMKC School of Dentistry. The past five classes at UMKC have graduated 19, 19, 21, 23 and 27 Kansas students respectively!

The new Advanced Education in General Dentistry residency program that began in Fall 2009 at Wichita State University graduated its first class of residents last summer and will house around 10 dental students in each class of a two-year residency program that will include a rural rotation during the second year once it is fully operational.

The KDHE Bureau of Oral Health Workforce Cabinet was created in Kansas and is exploring innovative ways to increase the dental workforce in Kansas including :

- o Assist with Dental Recruitment Efforts by Networking with Dental and Dental Hygiene

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Programs, working with Dentists and Safety Net Clinics.

- o Promote Kansas as a Great Place to Live and Practice- Collaborate with Kansas Chamber of Commerce, Workforce Development
- o Support for Isolated Dental Professionals in Rural and Underserved Areas
- o Creating a Dental Job Website and Facebook Page
- o Dental Clubs

The total number of dentists practicing in Kansas has increased by 17% since 1997 according to Kansas Dental Board licensure numbers.

- The statewide full time equivalency of general dentists increased by 7% in an eight year span from 2000 to 2008 according the Kansas Department of Health and Environment.
- The statewide full time equivalency of dental hygienists increased by 43% in a nine year span from 2000 to 2009 according the Kansas Department of Health and Environment increasing the productivity of dentists.
- The growth in the number of dentists and dental hygienists both outpaced the population growth of the state of Kansas which grew by only 6.1% from 2000 to 2010 according to the U.S. Census Bureau .
- In 2002 the KDA worked with the Kansas Dental Hygienists' Association to create a new Extended Care Permit dental hygienist that could to dental hygiene procedures without direct dental supervision with underserved populations.
- Kansas' own "Keep Kansas Smiling" oral health report card gave the state a "B" in 2009.
- The Kaiser Family Foundation ranks Kansas 17th in dental and medical Medicaid access for children 0-17. Missouri ranks 41st, Oklahoma ranks 37th, Nebraska ranks 34th, and Colorado ranks 31st.
- Nationally, after a low of 3,810 dental graduates in 1996 there has been a steady increase of dental graduates as new schools have opened and others are increasing the size of their classes and in 2008 4,796 students graduated from U. S. dental schools – a 26% increase in 13 years.
- The number of dental indigent clinics in Kansas (including CHCs and FQHCs) number 21 and growing...a short time ago it was only five.
- Committee passage of HB 2241 will allow dental franchisors like Comfort Dental to do business in Kansas who will help to recruit dentists to our state.
- The Governor's Rural Opportunity Zone legislation promises to provide an incentive for dentist to locate in the state most depressed counties.

It's also of interest to note that even with PAs and ARNPs there are actually more Primary Care Health Professional shortage areas (94) and Mental Health Professional Shortage Areas (106) than there are Dental shortage areas.

Let me be clear that the improvements I've cited does not mean there are not barriers to dental care that prevent Kansans from receiving dental care that should be addressed. To that end, the KDA has introduced a comprehensive oral health initiative currently in the Senate Committee on Public Health and Welfare.

Our Comprehensive Oral Health Initiative has many parts, some of which may be removed while similar alternatives like the Rural Opportunity Zone legislation and viable alternatives our ambitious goals to improve oral health are pursued.

Though not financially or politically feasible at this time, dental Medicaid for adults is a critical component to truly improving oral health in Kansas. For each of the past 10 years the Kansas Dental Charitable Foundation has treated thousands through its Kansas Mission of Mercy (KMOM) free dental clinic. Dentists are both applauded for the care they provide at KMOM and scolded for not doing more. People ask, "*how can that many Kansans be without a dentist...we must need more!?*" At each of the first six KMOM events we received grant funds to survey the patients to help find an answer to that question. An average of 8% of the patients said they didn't like to go to the dentist or didn't think they needed care, less than 3% said there was no dentist in their area and an overwhelming majority of **87%** said they did not have insurance or other means to pay for a dentist.

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The KDA also supports the expansion of services for dental hygienists. As I mentioned previously, in 2002, the KDA and Kansas Dental Hygienist Association hammered out the agreement that became the Extended Care Permit (ECP) Dental Hygienist. Our concept creates a further expansion to the Dental Hygienist Extended Care Permit law to create an ECP III. An ECP III would have the same infrastructure, practice locations/populations and dental supervision that the current ECP I and II have and as such would not create the bureaucracy of an entirely new practitioner. At this time ECP II practice locations/populations include nursing homes, prisons, indigent health clinics, head start programs and children in schools, but we are amenable to the possibility of expanding it to more practice locations. The ECP III Dental Hygienist would be allowed to use additional procedures that would assist them in treating these patients – but DO NOT include surgical procedures.

These new procedures that the ECP III dental hygienist could perform are:

- (A) Removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci;
- (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board;
- (C) the application of fluoride;
- (D) dental hygiene instruction;
- (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities;
- (F) identification and removal of decay using hand instrumentation and placing a temporary filling, including glass ionomer and other palliative materials;
- (G) adjustment of dentures, placing soft relines in dentures, checking partial dentures for sore spots and placing permanent identification labeling in dentures;
- (H) Smooth a sharp tooth with a slow speed dental handpiece;
- (I) Use of local anesthetic, including topical, infiltration and block anesthesia, when appropriate to assist with procedures where medical services are available in a nursing home, health clinic, or any other settings. If the dental hygienist has completed a course on local anesthesia and nitrous oxide as required in this act
- (J) Extract deciduous (baby) teeth that are partially exfoliated with class 4 mobility;
- (K) prescription of fluoride, chlorhexidine, antibiotics and antifungal as directed by a standing order from sponsoring dentist,

I hope you will consider this alternative to the Registered Dental Practitioner. Thank you for the opportunity to appear before you today.

Dr. Paul Kittle, presented testimony in opposition to the bill. ([Attachment 16](#)) I am a retired Army Colonel, and directed the US Army Residency Program in Pediatric Dentistry. I have been in private practice in pediatric dentistry in Leavenworth since 1994 and does accept Medicaid. And yes, if I look familiar...I am the one who practically begged you to mandate general anesthesia operating room coverage to young children, with extensive dental needs, who could not be treated in a dental office. And thank you. You have helped a significant number of children not become adult dental phobics by passing that legislation. You did... what was right for Kansas children!

I am now here to ask you to again to do what is right for our Kansas children. You have a proposed bill before you that would significantly alter how dental care would be provided in the State of Kansas. I am here to ask you to vote against this proposal and I am passionate about my opposition to it!

Kansas has exceptional dentists (some nationally renowned) who CARE for our children. My pediatric dental colleagues and I have participated in Kansas Mission of Mercy projects in 9 different areas throughout the State. My time away from my business and my family, my materials, my paid staff, my transportation costs, my hotel costs. Don't tell me we don't CARE! Why are there thousands of adults and children at KMOM? It's NOT because the dentists are too busy to treat them...NO... it is because

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the patients cannot afford dental treatment, or they do not have transportation, or they do not value oral health care until it's too late. (See the copy of the letter submitted with my written testimony). They either have lost their job, or have no dental insurance, or have extensive and costly dental problems, or have a Medicaid card. Well, well...what about the Medicaid card?? There is, NO adult Medicaid card in Kansas. There is no State benefit. So, if you are an adult and you do not have money...and the State does not provide dental benefits for you ...and you do have dental problems...you go to KMOM! Children...We just treated hundreds of children at the KMOM in Hutchinson 3 weeks ago. But...there are 2 exceptional pediatric dentists in Hutchinson and they DO accept the Medicaid card. And..yes...only 33% of Kansas dentists accept Medicaid in Kansas. Why...because just like where you work, or the business you own...dentistry, is a business. Last year my practice submitted \$45000 in Medicaid claims to the State...and they paid us \$19,350...that's 43% of what I billed. Now...I, like any business have to pay for equipment, materials, rent, utilities, etc, etc. [and that costs me 60 cents of every dollar] and, I provide jobs to 20 Kansans in my practice...so...I lost over \$7,500 treating the children on Medicaid. But I am fortunate...the practice is successful...and I made a decision to lose money to care for these children! That does not work as a business model in the United States! (and by the way, 90% of Kansas pediatric dentists treat the children on Medicaid)

SAFETY

I spent 4 years of college and 7 years of graduate and postgraduate education in learning how to become a dental specialist for treating children. Thousands of hours learning not only the surgical skills required of a dentist, but, of equal importance, hours and hours and hours of growth and development in children, the psychological development of children, behavior management of children [2 years, in fact, of advanced education learning how to treat just children]...and yet, the proposal before you allows a disproportionate number of dental procedures to be performed on children by someone with little education in these most important areas. This bill proposes to lower the standards of dental care for Kansas children. That is NOT ACCEPTABLE! We are not a third world country! We (the United States) lead the world in how we care for our children. We CANNOT allow a dental hygienist, no matter how well intentioned, to drill into the nerve on a primary tooth, to extract a solidly embedded primary molar. These are things that **I** worry about every day when I perform these procedures but yet we are going to allow someone with little training and even less experience to perform on a child...talk about creating phobic adults!!! Would you want your grandchild or your child treated by a person who is not a dentist???

“THE PROBLEM”

Madame Chair and Committee Members, it is a known and accepted fact that persons of low socioeconomic status have more dental problems than the rest of the population. The problem is NOT that there are insufficient Kansas dentists to treat those with a dental need, the problem is NOT that there is NO dentist CLOSE BY, the problem is that even when and where care is available, the value and the importance of oral health is not understood and THE APPOINTMENTS ARE NOT KEPT or the patient waits until the pain is intolerable before seeking care. I have kept meticulous stats since the first of January in anticipation of having to give this testimony...and, do you know how many appointments children on Medicaid failed at my office???

EDUCATION

This is a problem of education, this is a problem of transportation (even when the office is only several miles away), this is a problem of lack of understanding and valuing oral health until an emergency occurs. What is the solution to these problems???

I strongly suggest to you that it is a problem in EDUCATION. Cavities are preventable! Cavities are infectious! NO KID IS BORN WITH CAVITIES! Mom...or dad...or adult patient...Do you have hundreds or thousands of dollars to spend on your dental care? The disease is preventable. So...here's what you do...you don't share spit with your kid because it's full of cavity causing bacteria...you don't put them to bed or down for a nap with a bottle...you don't fill a sippy cup with apple juice or milk and allow them to sip on it all day long! I just spent 1 hour on Saturday

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giving a prenatal class to couples at St John's Hospital in Leavenworth telling these same things to all the parents about to have their first baby. I have been giving this class monthly for 15 years! Only 1 kid that I know whose parents attended these classes had brought me a child with cavities!

You want to spend money on dentistry?, the Kellogg Foundation wants to spend money on dentistry?, the Pew Foundation wants to spend money on dentistry?...don't socialize dentistry...EDUCATE the socioeconomically disadvantaged! Use the funds poured into the effort to change the dental law, to educate. Or, better yet, the Kellogg Foundation is estimated to have a corpus of \$8 BILLION, generating over \$250 million dollars in interest yearly. The Kellogg Foundation or the Pew Foundation wants to help?, KAMU wants to help?, the United Methodist Ministry wants to help?, Oral Health Kansas wants to help...?, Kansas Action for Children wants to help...dentistry...DON'T lower the standard of care!! Get Kellogg to donate \$10 million annually to Kansas and use it to implement adult Medicaid and to assist the State of Kansas in funding an adequate Medicaid payment rate so that dentists can run their business can afford to be able to treat Kansas adults and children. (And you think it doesn't work...Michigan and South Carolina adjusted their State reimbursement fees to match the level that Delta Dental pays...and guess what...75% of the dentists in those states now treat Medicaid patients!) Do NOT LOWER our standards of care! Do NOT subject children to a less educated dental practitioner. EDUCATE the poor. AGGRESSIVELY PURSUE permanent, private funding from those philanthropic organizations who say they want to help. THE DENTISTS OF KANSAS CARE about taking care of our own citizens! I ask you please to NOT SUPPORT this misguided legislation.

Glenn Hemberger, a pediatric dentist and President of the Kansas Dental Board, presented testimony in opposition to the bill due to the Board's concern for patient safety and appropriate patient care. (Attachment 17) The Board consists of nine members: six dentists, two hygienists and one public member. The mission of the Dental Board is to protect the public. Our protection process involves licensure, regulation, and investigative oversight of the dental profession.

The Kansas Dental Board is particularly concerned about the registered dental practitioner's duties listed under Section b, page 1,(line 22-33) of the bill, i.e., working under general supervision. Direct supervision is where there is a dentist present to oversee the treatment rendered and to provide direct and immediate assistance when necessary. Under general supervision, there may be no dentist present. Why is general supervision such a concern? If there is one consistency in the practice of dentistry it is that procedures frequently do not go as planned. Frequently, complications occur when finding more disease or structural damage than anticipated. These problems, in part, are due to the limitations of our diagnostic aids available including X-ray and visual exams. When problems are encountered, the dentist has to rely on his/her extensive training and experience to complete the treatment. The duties listed for the registered dental practitioner allows such person to encounter these complications, but their training does not allow them an avenue for proper completion. Although HB 2088 Section 1 (b) requires the supervising dentist to provide or arrange with another dentist to provide the necessary treatment when treatment requirements are more than the register dental practitioner can provide, the proposed bill permits this to be done through "distance technology". Let me give you just two examples that give the dental board concern:

Item (27):

The registered dental practitioner is allowed to perform a pulpotomy on primary (baby) teeth. This procedure involves the removal of the upper portion of the nerve (or pulp) of the tooth when decay has infected it. Many instances, however, the infection goes beyond the upper portion of the pulp and extends down the roots. This requires a pulpectomy or "baby tooth root canal" treatment which the therapist is untrained to perform. The tooth must then be temporized and referred to a dentist for treatment to be completed.

Item (19):

The registered dental practitioner is allowed to perform extractions of primary teeth. The removal of primary teeth can be a very complicated procedure sometimes requiring the *sectioning* of the tooth to prevent breaking the roots off and causing undue post-treatment discomfort for the patient. The therapist is untrained and prohibited from performing any sectioning of the tooth (item 20) or the removal of root fragments if and when the roots are fractured. Again the patient will have to be sent for another

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appointment with a dentist to reopen the area and complete the root removal. In both of the above examples, the child patient will have to be reanesthetized and subjected to unnecessary second appointment. This may not seem that significant to an adult, but to the child patient, being reanesthetized (getting another shot) and having the same procedure redone can have a lasting negative impression.

If any of the above two examples were routinely done today by a practicing dentist, the dental board would consider this *below* standard of care.

The Dental Board also speaks in opposition of this proposed Bill because the education process a written is not clear.

- It does not define education as full time or part time, nor does it address content, classroom or clinic hours
- While the proposed Bill states that, in order to practice, the registered dental practitioner must also be a licensed dental hygienist, it does not require completion of dental hygiene school or licensure as a dental hygienist prior to enrollment.
- Unlike the training for dentists and dental hygienists, there is no provision for approval of the training program for dental practitioners by the Kansas Dental Board – either by independent evaluation or through an accepted entity like the Commission on Dental Accreditation.
- Because the proposed professional does not exist at this time, no educational institution in the state of Kansas has developed a curriculum for training yet. The Board has concerns that this time limit will place undesired restrictions on the educational institutions that provide the proposed dental practitioner education (July 1, 2013).
- The bill also specifically prohibits extending the education program beyond the stated number of months (18). The college or university must be permitted to act if it is determined that additional training is necessary for an individual or group of students to gain competency.

It is the Dental Board's position that this presents a risk to the public.

This bill requires 2 new and additional members be appointed to the Kansas Dental Board. The proposed registered dental practitioner is required to also be a licensed dental hygienist. Licensed dental hygienists are currently members of the board. The requirement of 2 registered dental practitioners is disproportionate to the anticipated numbers of providers.

John Fales, a pediatric dentist with a practice in Olathe, Kansas presented testimony in support of the bill. (Attachment 18) I am currently the President of the Kansas Association of Pediatric Dentists and I am here representing that organization and myself. I have practiced dentistry in Kansas since 1982 and have specialized in pediatric dentistry since 1989. I have been an active Medicaid provider since 1982 and I am here today because I am opposed to House Bill 2280.

The road I took to becoming a pediatric dentist was greatly influenced by other pediatric dentists who encouraged me to follow that path of study only if I was doing it for the children. I believe that is the reason that I changed my direction and began the rigorous course of study that resulted in my becoming a specialist in this wonderful practice of pediatric dentistry. I have always felt that as a pediatric dentist I have a responsibility to be a child advocate particularly in the area of oral health. Another part of my practice that I feel very strongly about is the area of oral health care for patients with special health care needs.

Hubert Humphrey said in one of his last speeches, "...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."

It is my belief that this bill would not demonstrate that our government desires the best level of care for the children, the elderly or those in the shadows of life.

Those supporting the bill have stated that we have an access to care problem in Kansas. I suspect that since I practice in Olathe, there are those who would say that I have no idea what access to care issues are. I respectfully disagree. I have participated in 9 Kansas Mission of Mercy projects and two MOM projects in other states, New Mexico and Colorado. I am also a volunteer dentist in the Donated Dental Services program. I serve on the American Academy of Pediatric Dentistry's Advocacy team. I have conducted many free dental clinic days in my office in conjunction with the American Dental Association's Give

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Kids a Smile program, I have participated in annual Team Smile events and in Olathe I participate in several programs with the Olathe School District to provide dental care for children in need. I understand there is need and with my amazing team at my office we do much to help children needing dental care. Last year alone my team and I provided around \$100,000 worth of free dental care to patients in Kansas with no financial help from any government agency.

I am not alone. There are dentists all across this great state who do exactly what I do and they ask for no pat on the back because they are doing something from their heart. Most of the pediatric dentists accept Medicaid patients. I tell you this because I think it is important to understand that dentists in Kansas want to help those less able to help themselves. You have already heard the numbers that state that Kansas dentists provide over \$46 million dollars in free dental care. The state of Kansas only provides around \$30 million dollars through the Kansas Medicaid program for dental care. I just received a Form 1099 from the State of Kansas indicating that I was paid over \$153,000 for providing dental care through the Medicaid program. The total amount my office billed for those services was over \$390,000. As many of the pediatric dentists in Kansas do, I choose to take this tremendous loss because providing care for kids is the right thing to do. Many dentists are unable to absorb this kind of loss and keep their doors open. I believe Kansas dentists know about charitable giving and that a need exists.

What can we do to change that need? I believe that we do not have an access to care issue but rather a barrier to care problem. I base that opinion on my experiences in Olathe and stories I have heard from parents at the many Mission of Mercy projects I have participated in and in my office. I have heard from parents that they are working two, sometimes three jobs to provide for their kids and are not able to take time off or are not allowed by employers to take time off from work for fear of losing their job! Many times these parents have a Medical card for their children or other insurance but can't afford the risk of losing their job. I have heard from parents who wait over 3 months just to have their Medical card applications processed! These are 'barriers to care!'

As an example, the Olathe School District, with help from nearly 30 Olathe dentists started a program 4 years ago designed to provide free dental care for young students in need of oral health care. Dentists volunteered to see patients at no cost to the school district or to the parents. In the first year of the program, only 5% of the children identified as needing care made it to a dentist for the free care. The second year, we got 16% of the kids to that free care and the third year we got to 19%. That to me is not a great success. Free care was available less than 5 miles from where these kids live but they didn't get care. Why? I can suggest some reasons; lack of understanding of the importance of good oral health on the part of the parents, inability to get to the dentist providing the free care because of transportation issues, fear of discovery by undocumented parents, fear of losing a job? I could go on and on with ideas and I will be honest in saying I do not know the exact reasons. I do know that when there are over 30 dentists with the desire to provide free care to these kids and less than 1 in 5 children make it to the dentist's office that are less than five miles from their homes, this is not an access problem.

This year we have a program where kids identified as needing care are brought to my office by the school district and I provide free care. The parents only need to agree to the care and provide consent. They go to work, or whatever other responsibilities they have and every child gets dental care at the highest level available. We have 100% of the children identified as needing care and scheduled for an appointment receiving that care.

Restorative dental care, surgical dental care and diagnosis of oral and dental disease conditions are parts of dental care that make it a complex science. The training and experience that a licensed dentist brings to the table in Kansas is unmatched anywhere in the world. To lower the training and experience required for a non-dentist practitioner to treat Kansas citizens is not a responsible act.

The bill would allow a non-dentist practitioner to perform extractions of primary teeth as well as permanent teeth. I can tell you that the last 'simple' extraction of a primary tooth, I performed, was only 'simple' after the tooth was lying on a piece of gauze sponge. The number of possible untoward outcomes from extraction of any tooth is dizzying. I can only begin to imagine the scenario in a distant location somewhere in western Kansas with a small 3 year old child, terrified and in extreme pain due to a dental abscess enduring the most excruciating experience of his young life while a young, minimally trained, non-dentist practitioner attempts to manage the behavior of this screaming child and the parents who are also terrified watching their child have a primary tooth extracted. Managing a situation like this requires training, education and experience that a non-dentist provider will not have.

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The bill also would allow the restoration of primary and permanent teeth. Unfortunately, this too would lower the standard of care in our state for those people treated by a non-dentist practitioner. Most people do not understand and would, quite frankly, be bored to death with trying to understand the thought process that goes into making a decision about what material or method to use to restore a tooth. The understanding of dental materials and their use is not something to be taken lightly. Use the wrong material and you risk failure of the restoration. This leads to a return visit and, additional expense, for repair of the failed restoration. I do not believe that a child deserves to be put through two or more procedures just because the non-dentist practitioner didn't have the full understanding of the materials and the processes being used. Again, picture if you will, the young patient being seen by the non-dentist provider, crying, uncooperative, scared, tired and all of this because the non-dentist practitioner is ill-equipped and not as qualified to manage the situation as a licensed dentist would be able to do.

We have an opportunity to do the right thing for those unable to provide for themselves. These are your constituents. They are the people we as a society are charged with caring for. I see myself and all dentists as their advocates and I ask that you not allow this bill to become a law of the State of Kansas. The weak, the small, the unable deserve better than a second tier of dental care that you and I would not choose for ourselves. As my dental team says every morning before we start our day, 'do the right thing' and the right thing in this instance is to not allow a non-dentist practitioner to be allowed to provide care for the people of Kansas.

Mahatma Ghandi said, "A nation's greatness is measured by how it treats its weakest members." Kansas should demonstrate that we are a great state and we will always treat our weakest members with the greatest respect and not settle for inferior care for those people. Thank you for this opportunity to share my concerns.

Christy Gunter was unable to stay for the second half of the hearing and presented written testimony only in opposition to the bill. (Attachment 19) Christy is a survivor of domestic violence and currently working on her doctorate in global health and wholeness. She stated she is dreadfully poor and she is trying to stand up on her feet again following an experience with abuse. Since this is the backdrop of her life, she is educated and passionate about issues pertaining to what happens to the poor, of which circumstances caused her to be a part.

There are two things about the bill which cause concern. First, those who are proponents of this bill believe there is a lack of quality care available for the number of people who need assistance and thus propose non-dentist practitioners be made available to those who need to participate in the Kansas Medicaid program. This is simply untrue. She lives in Wichita, the largest city in Kansas, and there are a great number of dentists available in my area. Anyone who lives in the city of Wichita should be able to access a dentist. But she could not.

Even though she is located in an area with multiple dentists, she still could not find dental care for her four year old son. This was not from a lack of effort on her part. One day she called a local clinic eight times. Another day she left a message for a pediatrician recommended dentist. No one returned her calls. No one could see her. The dentists are physically present but she could not access them.

She was forced to wait 8 ½ hours in a free dental clinic in Hutchinson Kansas and fortunately receive care from a dentist who practices in Olathe Kansas. This is surely indicative of a more serious problem than a lack of quality care available for the number of people who need assistance.

Therefore, the issue is *not* access to a large enough population of licensed dentists. The issue is found in the obstructions of access to the available dentists. In her case, simply being poor and having Kansas Medicaid as my insurance was her obstruction, nothing more than this.

The second thing that causes concern about this bill is that if it passes, because she is poor, her son would not have access to qualified persons for dental work. He would be forced to have major dental surgery performed by a non-dentist practitioner. Her adorable, energy-filled child would be forced to see someone with less experience and less training to handle emergency situations. He could quite possibly suffer greatly because of her poverty.

Why should she not have access to the same care in her poverty as the person with the finances to pay a qualified licensed dentist? Does her time in poverty, induced by running away from abuse, mean she does not deserve a licensed dentist? To allow the wealthy access to qualified dental surgeons while denying access to the poor or those with disabilities is simply dehumanizing. This is not who we are as a country. We were meant for something better than this.

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Hear the voice from the oppressed and poor—we deserve better care. We need better care. Thank you.

Dr. Jeff Stasch presented testimony in opposition to the bill. ([Attachment 20](#)) I have maintained a general dental practice in Garden City for 27 years. I have served on the dean's advisory board at the University of Nebraska Medical Center College of Dentistry, and Target: Rural Access; a consortium made up of dental leaders from South Dakota, Wyoming, Nebraska, and Kansas. For the past 4 years, I have served on the ADA's Council on Access, Prevention, and Interprofessional Relations—specifically tasked with looking for answers to the problems we are addressing here today. I am a cofounder of the Kansas Mission of Mercy, and the founder of America's Dentists Care Foundation, which to date, has provided 28 million dollars in care to over 60,000 patients in 14 states. I have worked at mission projects and seen the scope of the problem, in towns both large and small, in Connecticut, Wisconsin, Illinois, Iowa, Nebraska, and Oregon to name a few---as well as 10 projects here in Kansas.

It is generally accepted that 50% of Americans do not see the dentist regularly, and mission work has shown that these 50% have significantly more than half of the dental need. But it is the type of need that is so shocking --not simple little fillings but what in the profession we call "bombed out teeth". We pull on average 3,500 teeth at a project; to give you an idea, that's two five gallon buckets full of teeth. Simple and easy are not words we use---we have 4th year dental students, after 7 and a half years of college, mind you, that can find precious little clinical dentistry to do inside their comfort zone.

In dental school, we had an Endodontics professor, who said that he could teach a 13 year old how to do a root canal. But the point that he made to us was that it was the combination of anatomy, physiology, biochemistry, histology, patient management, and a myriad other factors, that tell us what needs to be done, how best to do it, and predict potential outcomes.

I live so far out in rural Kansas that we don't walk around at night without flashlights, for fear of falling off the edge....it is a lonely place to be when something goes wrong, and you are the only game in town! People ask "what is a simple extraction"? The answer is, "one that came out easily and predictably" with the emphasis on the past tense—after the procedure is over. No x-rays can reliably show all the shapes and irregularities of the roots, or the bone density of the patient, the 'brittleness' of the tooth, the proximity of blood vessels and a host of other important variables. I personally, within the last year, have scheduled a patient for what appeared to be a simple extraction, only to spend the next 2 hours sweating and praying for divine intervention!

Much has been said about access to care in rural areas, so we did a Zip code search of our patients, and found that they came from 17 counties. If they had trouble getting in to see us, friends, neighbors, or family always brought them, and many of these people have to drive a significant distance just to buy a loaf of bread. We hear about long waits for appointments, but if you call my office, or many of my peers, you will get in this week, or next....that number again, is 275-4782.

The proponents of this bill say that here in Kansas, the RDP would be just like nurse practitioners, or physician's assistants. I think it is a very great leap from sending a high school graduate to a vocational / technical school for two years and getting their associates degree, then sending them back for 18 months of additional training, to comparing them to a PA. And make no mistake.....PA's do not pick up a scalpel.....which is used to cut human tissue, just like the dental drill. What is interesting is that if you cut soft tissue, it will heal, even if you ignore it, in most cases. But if you cut a tooth, it is gone forever.....the very definition of an irreversible procedure.

It is my firm belief, that if we doubled the number of dentists in the United States, we could not service all the need that exists.....if there was a way to pay for it. We cannot drill our way out of this situation. The only solution lies in education and prevention. If we start educating parents before the baby comes, and carry it into the preschools and K through 12....healthy choices, fluoridation, proper nutrition, good hygiene will turn the tide. This registered dental practitioner can be likened to giving a person a fish—they are fine for today, but will be hungry again tomorrow. Education.....Prevention....is the only thing that will pay dividends to the citizens and tax-payers of the state of Kansas.

Dr. Mark A. Herzog, a private solo practicing Dentist in Ellsworth Kansas, presented testimony in opposition to the bill. ([Attachment 21](#)) I have been in practice in Ellsworth for going on 25 years and have accepted Medicaid all 25 years. I have endured the bureaucracy of Medicaid and the other frustration that many of my colleagues have endured. Many a time I have wondered why I continued to accept Medicaid patients and continue to endure the difficulties. These difficulties ranged from who is eligible and when. What am I going to get paid per procedure? When am I going to get paid? What supporting

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documents do I need to send along with each procedure? Am I doing too much at one appointment? Who authorizes the procedure and who pays for the procedure and when there are discrepancies, who do you call to clear it up? Are the patients going to show up on time or even at all? And once I correct their dental needs are they going to follow up with the needed home care to sustain a healthy mouth.

Right now Medicaid is only for children and many come from economically and or socially depressed households. There was a time when each Medicaid enrollee was given an ID card each and every month so we had to verify every time if they were still eligible for the treatment scheduled for that day. If it happened to be that the appointment was on the first of the month they may not of received their new card for that month so do we take a chance that they are eligible or not or do you error on the side of safety and reschedule? Either way we would lose, in that we treated them and they were not eligible or we have an unproductive hole in our schedule. Time is money and we just got burned again. Now as to what we were going to get paid? Some preventative procedures we would get close to breaking even. But the problem was that they got the same procedures done at a different office 5.6 months ago and therefore they were not eligible for those procedures because the full 6 month had not past. Or they needed an emergency root canal and we couldn't get it done because we had to send it in on a predetermination. Pain and suffering on the patient's part and a scheduling and pain management issue on our part. We also could not get reimbursed for posterior composite restorations ,white fillings, but had to settle for the reimbursement rate of a silver filling. If a Dental sealant came off that was placed at another office I could not get paid for replacing it. I have done thousands of reseals knowing that I would never get paid for it but, couldn't morally not do it when I am doing other sealants for the patient. I had a patient in the other day that amazingly had outstanding home care no fillings and no decay. He had trauma to his upper front left tooth and had a porcelain crown present. The sad thing was that he had fractured it. Good looking kid and polite but was self conscious of his chipped tooth. We called Medicaid and that said they would pay for it but certainly not at my usual and customary fee. Well the lab fee will usually run about \$150 and my chair time a little over one and a half hours. Even if I get paid at 50% of my fee I still lose money on the deal. So like many of my colleagues we will suck it up and do the crown anyway. These are just some of the examples us Medicaid providers have endured. Then to whom, what and where do we send everything in to. There was a time when EDS and Doral dental both administered the Medicaid program. You talk about a bureaucratic nightmare. The only way I could get anything looked at that they denied was a family relative worked for one of the entities and we earmarked everything to their attention. I am sure many of my colleagues threw in the towel as far as being a Medicaid provider. Then we have the problems of how best to schedule our Medicaid patients? Do we just schedule them all at once and treat on a first come first serve bases, and if we don't have time to see them tell them to try again on another day? Do we schedule them into our regular schedule and hope and pray that they show up on time or at all? Medicaid patients are on average less reliable the non Medicaid patient. As for if we will ever see them again once we get all their treatment completed will we ever see them again for follow up maintenance which is critical to maintain optimal dental health. They are often a transient population who move and leave no forwarding address and no way of finding out if they intend to keep their 6 month recare appointment. Or their phone numbers have changed and we have no way of notifying them of their up coming appointment. Do we take them off the schedule? Leave them and again hope and pray that they show up? Or do you double book them and tick off the whole staff because they showed up and we are really behind schedule for the day. Then we have the issue of having our reimbursement rate cut another 10 percent to help with the states overall budget. Talk about being taxed to death for trying to do the right thing. Then we have the left out in the cold adults who are qualified for Medicaid a lot who are the frail and elderly who are on so many medications that their mouths are as dry as the desert. They have rampant decay, ill fitting dentures and/or partials and they are having a hard time eating thus compromising the overall health. The only coverage they have thru Medicaid is extractions. So it leaves them with few dental options. That brings us to the over 21 adult Medicaid patient. Here again the only treatment Medicaid allows for them is extractions. That is why 85% of the treatment perform at the Kansas Missions of Mercy is on adult patients. Only 15% of the treatment at KMOM is on children because most of them can get treatment on their medical cards. Today Medicaid is much improved from a bureaucracy standpoint. It is now web based so that we know what the patient is eligible for prior to treating. There is only one entity to deal with and payment is usually received in 2 weeks.

So where does this all fit in with the mid level proposal? If the majority of those who are in dire need of Dental treatment are adult patients How is the mid level going to be able to treat them when there is no reimbursement other than extractions of permanent teeth which, under their guidelines does not allow them to do only the very non-complicated(what ever that is). If they are to serve in underserved areas like

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Ellsworth Co. or Lincoln Co. or Lyons Co. all counties surrounding my practice why aren't the Dentist in these Counties completely booked with Medicaid patients. (I was paid over \$76,000 last year by the State of Kansas, I don't even want to know what percentage I wrote off?) We don't turn away Medicaid patients and yet my practice is not booked out months at a time. We take care of our area of Kansas and sometimes beyond our area. If they are having an access to care problem in our area they are not doing their part to solve the equation. So even if we were inundated with Medicaid patients how could a mid level help me to alleviate the problem? Well like most practices in Western Kansas we own our own buildings with just enough room for me and my Hygienist to practice. We don't have extra room, extra equipment, extra staff and extra payroll to pay these individuals. And since they are limited to what I think they could do (the supervising doctor determines the scope of practice within the guidelines of the bill) How can I justify hiring a mid level? Well they could work unsupervised after 3 months of direct supervision (Who in a busy practice has time to look over there shoulders for 3 straight months to see if they were adequately trained) off site in a satellite office. Well here again who is going to build or buy an office at, lets be conservative \$150,000, Equipment 3 operatories at \$250,000. 2 staff at \$40,000 per year, \$50,000 general supplies and \$50,000 to payroll the Mid level. That comes to an initial total of \$540,000 to be bank rolled in the first year. Granted the building and the equipment could be put on a bank note, but who in their right mind would fork out that kind of money only to break even (not even likely to break even) because Medicaid only pays roughly 50 cents on the dollar. So what do we do? My solution is to entice more Dentists to locate in these rural areas. Now not all counties can support a Dentist but we already have a Dentist within a 30 mile radius of every part of Kansas. Do they all take a medical card, not at the present but give them an incentive (loan reimbursement for education, state tax relief for the portion of their write off, Increase the reimbursement rate. increase the number of Dental seats at Dental schools. Nothing will solve the problems of "access to care" better than good old healthy competition in areas that need better access and a financial incentives. Much like when KAMU received a Federal Grant for treating a qualifying population, they tried to use it strictly though FQHC clinics. When they realize they were not going to be able to spend all of the grant money they turned to Private Practicing Dentist to do the Job. We basically had 1 month to treat a lot of people in a short time. They had to limit the number of Dentist willing to help for fear of overspending their grant allotment. Kansas Dentist have been stepping up to the plate to help alleviate the Dental crisis in our state. Look at the millions of dollars of treatment we have provided to our fellow Kansans with the KMOM programs. A Kansas Dentist also on the average does \$33,000 of free dentistry in their practices a year \$33000 X's 1428 practicing Dentist that comes to over \$47 MILLION DOLLARS of free treatment to our Kansas underserved. You will find very few Kansas Dentist in this State who supports the mid level model. We understand we have issues with an aging population of Dentists in rural Kansas. But the solution is not an undertrained mid level. The solution is incentives to get more Dentists in the rural areas. A trend that has already started happening in the last few years. Don't let opinions from the East Coast tell Kansans how to take care of our underserved population. They deserve to be treated by a REAL DENTIST and nothing less. I thank you for your time and consideration.

Cindi Sherwood, a registered dental hygienist and a general dentist, presented testimony in opposition to the bill. ([Attachment 22](#)) I went to Wichita State and then later attended the University of Missouri – Kansas City. I am not unique, there are a number of dental hygienists who have continued their education to become dentists. I want to tell you about my experience having had both educations – that of a dental hygienist and a dentist.

First, let me say that there is no comparison between the two curriculums. The breadth and depth of the dental curriculum is much more rigorous than the dental hygiene courses. While the titles of many of the classes are similar – for example, periodontics (the treatment of gum disease) or pharmacology, the basic assumptions are completely different. The dental hygiene classes are based on the concept that the dental hygienist will work as a member of the dental team under the supervision of the dentist.

The dental hygiene curriculum does not teach diagnosis. The diagnosis of dental disease requires knowledge of the underlying science that is not taught to dental hygienists. This includes post graduate classes in cell biology, human anatomy, physiology, histology, biochemistry, microbiology, pathology, pharmacology, oral diagnosis and oral medicine. Dentists must manage patients with complex health situations that take numerous medications. A seemingly simple procedure can become problematic if there is no understanding of a patients health history or medications. There could be complications including bleeding, infection, cross reactions of medications with local anesthetic, pain and anxiety control problems.

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The pre-requisites for dental school are also more advanced than those for dental hygiene school. In order to be accepted into dental school, most students have a bachelors degree in either biology or chemistry. In Kansas, we have dental hygiene programs that accept students immediately out of high school and therefore can become licensed as a registered dental hygienist with two years of college. In the dark ages when I decided to go to dental school, I had to take two more years of chemistry, physics and math courses to be able to apply for dental school, and that was after I had a bachelors degree in dental hygiene. While no one has provided information on the exact curriculum the further 18 months of education that the dental practitioner would have, it can't compare to the 4 years that dental students have.

I looked at the American Dental Association Commission on Dental Accreditation standards for both professions. The Commission on Dental Accreditation was established in 1975 and is the recognized group by the United States Department of Education to accredit dental education programs. The CODA standards document says, " The dental hygienist functions as a member of the dental team and plays a significant role in the delivery of comprehensive patient health care. The dental hygiene process of care is an integral component of total patient care and preventive strategies. The dental hygiene process of care is recognized as part of the overall treatment plan developed BY THE DENTIST for complete dental care." This again verifies that the underlying premise of dental hygiene education is that they will be supervised by a dentist.

I also looked at the current outline of the curriculum for both the doctoral program and the dental hygiene program at UMKC to evaluate current information. The classes which teach dental students to diagnose, drill and fill, pull teeth, make orthodontic appliances, and crowns - all procedures which the proposed dental practitioner could do – take place all four years of dental school. First year dental students take dental morphology, clinical assisting, clinical decision making, operative dentistry lecture and lab, oral diagnosis, and dental occlusion in addition to their general sciences. Second year students take preventive periodontics, operative dentistry lecture and lab, anesthesiology, pathology, orthodontics, fixed prosthodontics (crown and bridge), medical emergencies, oral surgery, advanced periodontics, principles of medical and physical diagnosis, dental pharmacology and pediatric dentistry. These are all classes required to learn what the dental practitioner would be allowed to do. I did not include the classes on root canals implants and dentures and partial dentures that are not included in the dental practitioner scope of practice.

I will continue – third year dental students take oral oncology, dental biomaterials, oral diagnosis and oral medicine, periodontics II, oral surgery II, orthodontics II, treatment planning, review of preclinical dentistry, operative dentistry III, oral surgery III, therapeutics, dental behavioral science, diagnosis and management of orofacial pain and extramural clinical rotations. Third year students have 24 credit hours worth of clinic time treating patients. Fourth year students have dental behavioral science II, pathology III, anxiety and pain control, periodontal treatment planning, dentistry for special patients, pediatric dental seminar, practice management, extramural clinical rotations II, review of clinical dentistry, jurisprudence, practice management II and 26 credit hours of clinical treatment of patients.

My point is that you cannot teach someone to extract teeth, drill and fill teeth, perform pulpotomies, make appliances to treat TMJ, reimplant and stabilize knocked out teeth, numb and sedate patients with nitrous oxide, diagnose oral disease and formulate treatment plans , make orthodontic appliances, place crowns, - basically do everything a general dentist does except root canals – with 18 months of education on top of a superficial understanding of dentistry which is what you get with an associates or bachelors degree in dental hygiene.

I apologize for my passion if I seem a little overwrought. But this "solution " to the barriers to dental care in Kansas is no solution at all. I hope that I have helped you understand that a dental hygienist is not a dentist in training. There is clear safety concerns based on a lack of adequate education for the proposed scope of practice of the dental practitioner. The underserved do not deserve poor quality dental treatment – or a two tiered system of care – we must find answers that protect the public and help them receive safe, quality dental care.

Dr. David Hamel, President of the Kansas Dental Association, submitted written testimony only in opposition of the bill. ([Attachment 23](#)) Thank-you for allowing me to testify in written form, I regret I cannot make it in person. Having grown up in small town Kansas, lived my entire life there and began my dental practice life in a town of 400, I believe I can relate to many of the wonderful opportunities and challenges that exist here. As a rural dentist I have a unique perspective to understand the reasons, barriers

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and limits to the real life journey of first preserving and when needed recapturing oral health through appropriate treatment.

My objection to the establishment of a non-dentist practitioner in this bill is as much from the perspective of a taxpayer and a rural resident that wishes to see rural Kansans be given the best opportunity to maintain or attract new dentists to their communities.

Many of you have heard or read articles stating there are shortages of dentists and dental workforce in Kansas. It is possible for a mid level to actually help cause a shortage of dentists in areas of rural Kansas. I've enclosed a letter sent to me by a dentist looking to rural areas to settle and he expresses a concern that I share about rural Kansas communities facing additional barriers to attract dentists to live and work in their community.

Is there an uneven distribution of dentists in Kansas? Well, a little bit. About 73% of dentists practice in areas that contain 65% of the population. However, the location of dentists across the state pretty much follows the distribution of the population as a whole. Sure, there are areas in Kansas with no dentist. Specifically but not verified, by my unofficial count there are over 500 communities in Kansas without a dentist. But we are not going to put dentists in every one of those communities nor call them underserved. They are just too small. It is cost prohibitive and unnecessary. People in those areas do travel some to receive care and almost all other services. Fortunately all those areas have dentists in nearby communities. Only the most remote farmers are not within 30 miles of a dentist. I've included a map for you to see. The red circles indicate a 30-mile radius around a dental office, blue is 35 miles.

There are many convolutions that happen on paper for an area to receive a HPSA designation. It is a policy designation, not a measurement of reality. For instance, how far can you drive in 40 minutes, in western Kansas, on a primary highway? Most of us can drive 40 miles but for a HPSA designation, HRSA uses the idea you can only drive 25 miles in 40 minutes. HRSA also does not count all dentists and I found out I am no longer considered a whole dentist but am now only .8 of a dentist because I am over age 56. There are other convolutions, but I hope you see the point.

HHS says that a HPSA designation is a "first screening" for determining need. RuPRI (Rural Policy Research Institute) states only that a HPSA designation "may" indicate a shortage and KS Oral Health Officials concur with HHS in the statement that the designation means an area can apply for grants. Policy designation does not necessarily coincide with reality.

Another thing you will hear is that a non-dentist model exists and works well in other countries. I hope you realize the USA is different in many ways than other countries. That includes dentistry.

Included is a graph illustrating World Health Organization information on dentist per capita compared to these other countries. The USA is number one in the world, Jordan is second and Brazil is 10th. England is in the top 25 and New Zealand is not even close.

The USA has far more dentists than other countries and does not need a non-dentist practitioner. We also have the least amount of dental care purchased by the taxpayer. Observation shows that these other countries use the non-dentist practitioner as a building block for their nationalized or government subsidized systems for dental care. In the USA, about 6% of dentistry is purchased by the taxpayer, in Australia that rises to about 21%. In Europe it is higher but the information is combined with their national medical care. I have included a letter from a local partnering community group to share a success for an alternative to this bill.

Jessica Rogers, B.S. RDH presented written testimony only in opposition to the bill. (Attachment 24) I am a registered dental hygienist from Garden City, KS and have worked in private practice for the last five and a half years. I received my bachelors in dental hygiene from the University of Nebraska in May of 2005. I am proud to be part of the dental profession and truly enjoy making a difference in people's lives. After considering the proposed bill, I have several concerns.

The first thing we need to consider is patient care. Dentists have 8 years of intense education and training, and the RDP program will be an additional 18 months of training for hygienists who may only have a 2 year education. While they may be able to learn basic skills in this training period, there are so many other

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components to consider... will they be capable of properly diagnosing? what about treating medically compromised patients? I know from working in a dental office that sometimes a “simple” extraction can turn difficult in a hurry, or a “simple” filling can be deeper than anticipated and go to a root canal in a matter of minutes. These are situations that will arise and without the presence of a dentist, they are going to be real problems.

I know that there is a dental need across our state. I have been humbled by volunteering at five mission of mercy projects where I have seen some of this need first hand. Much of the need is what would be considered severe dental problems, often times it is a full mouth of infection and disease. The problem is not access to care. The majority of people could get to a dentist if they needed to. Many of them choose not to for reasons including fear, finances, and just not being educated in their dental health. I’m not convinced that by having registered dental practitioners, it will make a difference in the needs that are out there.

I serve patients in a rural area. Many of them drive a great distance to get dental care. However, they have lived in these areas all of their lives, and know that they don’t have a dentist next door. They choose to live in these areas and driving an hour for them is generally not an issue, it is a way of life. They drive that far to buy groceries, shop, see their medical doctor, and do other business. I grew up in rural Nebraska and can relate to this way of life. We drove 40 miles, to a dentist in another county, but we didn’t think twice about it. Again, I don’t think RDPs are the answer to solving dental need. I hope that somehow we can reach out to help people with needs. We need to do everything we can to educate people on the importance of prevention.

Thank you again for taking the time to consider this issue.

Dr. Ric Crowder, DDS, presented written testimony only in opposition to the bill. ([Attachment 25](#)) The Academy of General Dentistry is 35,000 member organization of general dentists that promotes life long learning with required continuing education, provides public education on dental issues and advocates for general dentistry.

The Academy of General Dentistry believes that :

- Only dentists should diagnose disease and develop treatment plans
- Only dentists should perform irreversible procedures such as extractions, fillings, pulpotomies, crown placement, tooth reimplantation
- Dentists should be present when local anesthesia and nitrous oxide are used by allied personnel
- Patient safety is at risk if this proposal goes forward
- The training of any new dental team member should occur through programs accredited by the ADA Commission on Dental Accreditation, which is recognized by the U.S. Department of Education
- The education of a dentist and a dental hygienist are not comparable. A dentist has minimally 8 years of post high school education and the proposed dental practitioner could have as few as 3 ½ years of post high school education
- Barriers to dental care in Kansas are many and complex, however proposing that a new dental provider will significantly reduce these barriers is at the least, naïve and suspect in origin.

The Kansas Academy of General Dentistry is strongly opposed to HB 2280 and asks that you vote to defeat this ill-conceived proposal on the basis of patient safety.

The Chair gave committee members the opportunity to ask questions. Questions covered items such as amount of education required and what exactly is included in the 18 month training; the 34 procedures the RDP would be allowed to practice and why they were chosen; the extent to which there are issues in Kansas concerning access to dental services and the cost of those services; whether or not the RDP's could administer nitrous oxide to the patients; the number of dentists taking Medicaid; the level of supervision the RDP would have from a dentist; the overall number of dentist in Kansas; the facilities in Kansas that

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offer dental training, etc. Kevin Robertson will provide the committee with an answer as to where new dentists are locating in the state. Chairperson Landwehr reported it was her understanding that Wichita State University was taking a neutral position on the bill.

After all questions were addressed, the hearing on the bill was closed.

The next meeting is scheduled for on call of the Chair.

The meeting was adjourned at 7:10 p.m.